Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Hypnotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Ambien CR, Doral, Rozerem, and Lunesta (single-source brand-name products) and any brand-name multiple-source benzodiazepine that has an FDA "A"-rated generic equivalent as identified by the ***Approved Drug Products with Therapeutic Equivalence Evaluations*** (also called the "Orange Book").

PA is also required for quantity requests greater than 10 units per month for hypnotics. Additional information about hypnotic use can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Hypnotic request	Quantity	Hypnotic request	Quantity	Hypnotic request	Quantity
☐ Ambien (zolpidem)	____	☐ Halcion # (triazolam)	____	☐ Rozerem (ramelteon)	____
☐ Ambien CR (zolpidem)	____	☐ Lunesta (eszopiclone)	____	☐ Sonata (zaleplon)	____
☐ Dalmane # (flurazepam)	____	☐ ProSom # (estazolam)	____	☐ temazepam	____
☐ Doral (quazepam)	____	☐ Restoril (temazepam)	____	☐ Other _____	____

Dose, frequency, and duration of requested drug	Drug NDC (if known)

Section I

A. Indication for hypnotic
☐ Acute insomnia ☐ Chronic insomnia ☐ Other _____

B. Is insomnia secondary to a vital concurrent medication or diagnosis?
☐ Yes. Please briefly describe and attach documentation. _____
_____
_____
☐ No

C. Has member been counseled on good sleep hygiene practices?
☐ Yes. Please briefly describe.
_____
_____
☐ No. Please explain why not. _____

D. Is request for quantities greater than 10 units per month of a hypnotic?
☐ Yes. Please briefly describe and attach documentation, including detailed treatment plan and therapeutic endpoints. _____
_____
_____
☐ No

Medication information

Section II

What other medications has the member tried for this diagnosis (sleep disorder)?
Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form) for your response to this question.

Drug name	Dates of use	Dose and frequency

Did the member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Please briefly describe details of adverse reaction, inadequate response, or other.

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*
Address		City	State / Zip *Optional*

Prescriber information

Last name / First name / MI			MassHealth provider no.	DEA no.
Address			City	State / Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date